

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

* * *

7 JOSHUA ABRAMS, an individual;
8 PRESTON FORTNEY, an individual; NOE
9 LUNA, an individual; SALESHP JATAN, an
individual; NANCI WIRTH, an individual;
10 ADAM YOUNG, an individual; EMERIO
BENAVIDES, an individual; JEFFREY
SHARP, an individual; ANA HLEDIK, an
individual; and FE HLEDIK, an individual,
11 all on behalf of themselves and all
similarly-situated individuals.

Case No. 3:16-cv-00454-MMD-VPC
ORDER

13 v. Plaintiffs,
14 PEPPERMILL CASINOS, INC., a Nevada
corporation; and DOES 1 through 100,
15 inclusive,
16 Defendant.

18 | I. SUMMARY

19 Pending before this Court is Plaintiffs' Motion for Reconsideration of Order Denying
20 Remand ("Motion to Reconsider") (ECF No. 17) and Defendant Peppermill Casinos, Inc.'s
21 Motion to Dismiss ("MTD") (ECF No. 18). The Court has reviewed the parties' responses
22 (ECF Nos. 20, 22), replies (ECF Nos. 21, 23), and Plaintiffs' accompanying exhibit to their
23 Motion to Reconsider (ECF No. 19-1).

24 For the reasons discussed below, the Court denies Plaintiffs' Motion to Reconsider
25 and grants in part Defendant's MTD.

26 II. BACKGROUND

27 In their amended class action complaint ("FAC"), Plaintiffs advance two claims
28 against Defendant: (1) violation of Nevada's Minimum Wage Amendment ("MWA" or "the

1 Amendment") and (2) violation of NRS § 608.1555. As to their first claim, Plaintiffs contend
2 that Defendant has violated the MWA by failing to provide qualified health benefit plans
3 consistent with NRS § 608.1555, which states that "[a]ny employer who provides benefits
4 for health care to his or her employees shall provide the same benefits and pay providers
5 of health care in the same manner as a policy of insurance pursuant to chapters 689A
6 and 690B of NRS." (ECF No. 1-2 at ¶¶ 73-75, 88-89; see also ECF No. 17 at 3 ("it is true
7 that Plaintiffs allege that Defendant has violated the Amendment by failing to provide the
8 same benefits and pay providers of health care in the same manner as a policy of
9 insurance pursuant to NRS Chapters 689A and 689B") (internal quotation marks
10 omitted).) Simultaneously, Plaintiffs' second claim contends that Defendant's proffered
11 health care benefits do not meet the requirements of NRS Chapters 689A and 689B and,
12 therefore, that Defendant has violated NRS § 608.1555. (ECF No. 1-2 at ¶¶ 93-94.)

13 In the Court's prior order (ECF No. 16), it denied Plaintiffs' motion to remand (ECF
14 No. 7), finding that complete preemption under the Employee Retirement Income Security
15 Act ("ERISA"), applied to Plaintiffs' second claim because NRS § 608.1555 "clearly
16 relates" to an ERISA-regulated plan. (ECF No. 16 at 5.) The Court also found that
17 Plaintiffs' reading of the MWA requires this Court "to determine whether the benefits
18 provided by Defendant fail to satisfy the requirements under NRS Chapters 689A and
19 689B," which is the second claim for relief as well as the legal theory advanced in support
20 of the first claim for relief. (*Id.* at 6.) Because "state causes of action that 'duplicate or fall
21 within the scope of an ERISA § 502(a) remedy' are completely preempted and hence
22 removable to federal court," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 206 (2004) (quoting
23 *Roark v. Humana, Inc.*, 307 F.3d 298, 305 (2002)) (internal alterations omitted), the Court
24 found removal of Plaintiffs' second claim for violation of NRS § 608.1555 to be proper.
25 The Court then chose to extend supplemental jurisdiction to Plaintiffs' first claim pursuant
26 to 28 U.S.C. § 1337(c). (ECF No. 16 at 6.) Plaintiffs now move for reconsideration of that
27 order.

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1 **III. MOTION TO RECONSIDER (ECF No. 17)¹**

2 Plaintiffs argue that, in the Court's order denying their motion to remand, the Court
3 misconstrued the allegations of the FAC because Plaintiffs "do not allege that Defendant
4 must provide particular benefits to [Plaintiffs]" or that Defendant has failed to provide a
5 "precise health benefit plan . . . as promised," and also contend that they "could not have
6 brought [their second claim] under § 502(a) of ERISA." (ECF No. 17 at 3, 4.)² The Court
7 disagrees and finds that it did not misconstrue the allegations in the FAC.³

8 **A. Legal Standard**

9 A court may relieve a party from a final judgment, order or proceeding only in the
10 following circumstances: (1) mistake, inadvertence, surprise, or excusable neglect;⁴ (2)
11 newly discovered evidence; (3) fraud; (4) the judgment is void; (5) the judgment has been
12 satisfied; or (6) any other reason justifying relief from the judgment. Fed. R. Civ. P. 60(b);
13 see also *De Saracho v. Custom Food Mach., Inc.*, 206 F.3d 874, 880 (9th Cir. 2000)
14 (noting that the district court's denial of a Rule 60(b) motion is reviewed for an abuse of
15 discretion).

16 Thus, a motion for reconsideration must set forth the following: (1) some valid
17 reason why the court should revisit its prior order; and (2) facts or law of a "strongly
18 convincing nature" in support of reversing the prior decision. *Frasure v. United States*,

20 ¹Plaintiffs base their Motion to Reconsider on Fed. R. Civ. P Rules 59(e) and 60(b).
21 (See ECF No. 17 at 2.) However, the Court's prior order was not a final judgment, so Rule
22 59(e) does not apply here.

23 ²Yet, in the next sentence Plaintiffs also assert that Defendant "has offered
24 substandard benefits plans to Plaintiffs." (ECF No. 17 at 3.) Plaintiffs seem to want to
25 challenge the quality of the benefits plan but to avoid stating so.

26 ³Plaintiffs are correct that the Court's prior order inaptly pointed to Nevada
27 Administrative Code ("NAC") § 608.102(1)(b)(2)(ii), which states that a health benefit plan
28 under the MWA that allows an employer to offer the lower-tiered wage is one that qualifies
 as an employee welfare benefit plan under ERISA (see ECF No. 17 at 4). That provision
 applies only in the context of employees who are unionized and where the employee
 health care plan is created pursuant to a Taft-Hartley trust. The Court pointed to it based
 on mistakenly reading NAC § 608.102(1) as a conjunction and not a disjunction. This
 error does not affect the Court's reasoning in denying remand.

29 ⁴The Court takes Plaintiffs' Motion to Reconsider to be based on the Court's
30 purported "mistake" or "inadvertence" in its prior order.

1 256 F. Supp. 2d 1180, 1183 (D. Nev. 2003). Motions for reconsideration are not “the
2 proper vehicle for rehashing old arguments,” *Resolution Trust Corp. v. Holmes*, 846 F.
3 Supp. 1310, 1316 (S.D. Tex. 1994) (footnote omitted), and are not “intended to give an
4 unhappy litigant one additional chance to sway the judge.” *Durkin v. Taylor*, 444 F. Supp.
5 879, 889 (E.D. Va. 1977).

6 **B. Discussion**

7 The Motion to Reconsider and accompanying reply, as well as Plaintiffs’ opposition
8 to Defendant’s MTD, make clear that Plaintiffs have misunderstood the meaning of NRS
9 § 608.1555 in arguing that their second claim is not preempted by ERISA.⁵ For that
10 reason, the Court clarifies its prior order by focusing exclusively on the statute’s
11 meaning—which applies only where there is an ERISA health care plan—so that it may
12 elucidate why Plaintiffs’ second claim is preempted.⁶

13 **1. NRS § 608.1555**

14 In Nevada, an employer has three choices: (1) provide no health insurance plan⁷
15 to its employees; (2) provide a health insurance plan to its employees by purchasing a
16 policy through a commercial insurance company;⁸ or (3) create its own health care plan
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20 Plaintiffs state that the “textual construction [of NRS § 608.1555] clearly
presupposes employers who do not provide benefits for health care.” (ECF No. 22 at 8.)

21 ⁶The Court agrees with Plaintiffs that their claims should be read independently of
22 one another even though the legal theory by which they argue for their first claim is also
23 the basis for their second claim. (See ECF No. 22 at 2, 3.) Considering each claim
24 independently, the Court still finds that the second claim was properly removed on the
basis of federal question jurisdiction, and that the Court has discretion to exercise
supplemental jurisdiction over Plaintiffs’ first claim.

25 ⁷The Court refers to a “health insurance plan” also as “health care plan” and “health
benefit plan.” It is important to note the distinction between a “plan” and an “insurance
policy” for purposes of ERISA preemption.

26 ⁸This is referred to as an “insured plan” because an insurance company provides
27 plan coverage. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (“[E]mployee benefit
plans that are insured are subject to indirect state insurance regulation. An insurance
company that insures a plan remains an insurer for purposes of state laws ‘purporting to
regulate insurance.’”).

1 for its employees,⁹ which may or may not be administered by an entity separate from the
2 employer. NRS § 608.1555 applies to the third category. Thus, based on the plain
3 language of NRS § 608.1555 and the legislative history behind that statutory provision,
4 the Court construed the second claim of the FAC to allege that Defendant acts as an
5 insurer by providing a self-funded health care plan to its employees and that Defendant's
6 plan fails to provide the benefits outlined in NRS Chapters 689A and/or 689B.¹⁰

7 When interpreting a statute, a court's "starting point is the plain language of the
8 statute" itself. *United States v. Williams*, 659 F.3d 1223, 1225 (9th Cir. 2011). If a statute
9 is unambiguous on its face, then that meaning controls and a court need look no further.
10 *Children's Hosp. & Health Ctr. v. Belshe*, 188 F.3d 1090, 1096 (9th Cir. 1999). However,
11 if a statute's meaning is not plain, a court may look to the legislative intent behind the
12 statute. See *Exxon Mobil Corp. v. United States Envtl. Prot. Agency*, 217 F.3d 1246, 1251
13 (9th Cir. 2000). As noted, NRS § 608.1555 states that, "Any employer who provides
14 benefits for health care to his or her employees shall provide the same benefits and pay
15 providers of health care in the same manner as a policy of insurance pursuant to chapters
16 689A and 689B of NRS." Because the statute's use of "provides" may be ambiguous as
17 to the fashion in which an employer provides its employees with health care benefits—
18 i.e., whether the employer provides a health care plan by self-funding it or whether it
19 provides a plan by purchasing a policy from a commercial insurance company—the Court
20 turns to the legislative intent behind the statute to understand its meaning.

21 In 1985, the Nevada legislature adopted NRS § 608.1555 through the passage of
22 Assembly Bill 647 ("AB 647"). While the primary purpose of AB 647 was to expand the
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24 ⁹This is referred to as a "self-funded plan" or an "uninsured plan"; "it does not
25 purchase an insurance policy from any insurance company in order to satisfy its
obligations to its participants." *FMC Corp.*, 498 U.S. at 54.

26 ¹⁰Plaintiffs state that "Defendant [] is not an insurer" or a plan administrator. (ECF
27 No. 17 at 2; ECF No. 21 at 4.) Given this purported fact and the Court's ensuing
discussion of the meaning of NRS § 608.1555, Plaintiffs' second claim is nonsensical as
pled. A claim under NRS § 608.1555 applies only where an employer acts as an insurer
28 for an employee health care plan.

privileges of dentists and regulate the dental care industry,¹¹ the text of NRS § 608.1555 appeared in a proposed amendment submitted by state congressman Bob Kerns. Congressman Kerns stated that this amendment, whereby NRS § 608.1555 would become law, specifically applied to self-insuring employers and “would make a policy statement.”¹² Important to Plaintiffs’ second claim is that the legislative history indicates NRS § 608.1555 was created in order to mandate that the requirements for health insurance policies provided in the state of Nevada by commercial insurance companies also apply to self-insured employers, i.e., those who create and fund their own health care plans.¹³ In other words, NRS § 608.1555 mandates that an employer who chooses to create its own employee health care plan provide within that plan the same sorts of health care benefits and coverage that insurance companies are required to provide pursuant to NRS Chapters 689A and 689B, which were enacted in 1971 in order to regulate the health insurance industry in the state of Nevada.¹⁴ By providing an insurance plan for its employees and not purchasing a policy from a proper insurance company, NRS § 608.1555 ensures that the employer itself is subject to NRS Chapters 689A and 689B and is treated in the same manner as an insurance company.

2. Claims for Violation of § NRS 608.1555 Prompted By ERISA

18 As Plaintiffs note, employers are not required to provide health insurance plans to
19 their employees. (ECF No. 22 at 6.) However, if an employer does provide an employee

¹²*Id.* at 13, 18, 37.

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26 State laws that regulate the health insurance industry are generally exempted from
27 considerations of ERISA preemption. See *Metro. Life*, 471 U.S. 724, 741 (1985). This
28 includes employee health insurance plans where an employer purchases a policy from
an external insurance company. *Id.* at 724-25.

1 health care plan, NRS § 608.1555 applies only where the employer itself creates and
2 insures the health care plan. Thus, a violation of NRS § 608.1555 may occur only where
3 there is a self-funded employee health care plan and where that plan fails to provide the
4 same health care benefits and pay providers in the same manner as policies of insurance
5 that are offered by commercial insurance companies. Taking this into consideration as
6 well as Plaintiffs' use of the term "proffered benefits"—implying an *existing* self-funded
7 health care plan—the Court found that Plaintiffs' second claim was premised on the
8 existence of a self-funded health care plan provided by Defendant.

9 Self-funded health care plans provided to employees by their employers are
10 considered employee welfare plans within the meaning of ERISA (i.e., an "ERISA plan").
11 ERISA defines an employee welfare-benefit plan or welfare plan as one which provides
12 employees "medical, surgical, or hospital care or benefits, or benefits in the event of
13 sickness, accident, disability [or] death." 29 U.S.C. § 1002(1). Employee welfare "[p]lans
14 may self-insure or they may purchase insurance for their participants" and their
15 beneficiaries. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). In the
16 Court's prior order, it found that under § 502(a) of ERISA Plaintiffs' second claim amounts
17 to a "clarification of rights" under an ERISA plan because NRS § 608.1555 "clearly relates
18 to an ERISA-regulated plan."¹⁵ (ECF No. 16 at 6.) Given the FAC's lack of facts as to how
19 any health care benefits and coverage provided by Defendant fail to comply with the
20 benefits and coverage mandated by NRS Chapters 689A and 689B—as those chapters
21 apply to self-insured employee health care plans—the mere contention that NRS §
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23 ¹⁵In the Court's prior order, it stated that NRS Chapters 689A and 689B relate to
24 an ERISA-regulated plan but could have stated more clearly that these chapters relate to
25 ERISA-regulated plans in the context of health care plans under NRS § 608.1555. (See
26 ECF No. 16 at 6.) Laws like NRS Chapters 689A and 689B are generally saved from
27 ERISA preemption by ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(a). See
Metro. Life, 471 U.S. at 746 ("If a state law 'regulates insurance,' as mandated-benefit
laws do, it is not pre-empted."); see also *FMC Corp.*, 498 U.S. at 61 ("State laws that
directly regulate insurance are 'saved' but do not reach self-funded employee benefit
plans because the plans may not be deemed to be insurance companies" and "[a]n
insurance company that insures a[n] [employee benefit plan] remains an insurer for
purposes of state laws 'purporting to regulate insurance'").

1 608.1555 has been violated required this Court to assume the existence of an ERISA
2 plan. Because the FAC's allegations imply that Defendant offers health care benefits
3 through use of the term "proffered benefits" but alleges that these benefits do not meet
4 the requirements of NRS Chapters 689A and 689B—hence the FAC's request for a
5 declaration of such—Plaintiffs' second claim clearly could have been brought under §
6 502(a)(1)(B) to clarify rights under an ERISA plan.¹⁶

7 The Court was correct in denying Plaintiffs' motion to remand. Therefore, Plaintiffs'
8 Motion to Reconsider is denied.

9 **IV. MOTION TO DISMISS (ECF No. 18)**

10 Defendant moves to dismiss Plaintiffs' FAC on three grounds: (1) both claims in
11 the FAC are preempted by ERISA; (2) the legal theory advanced by Plaintiffs as to how
12 Defendant has violated the MWA is not viable; and (3) Plaintiffs fail to allege any facts in
13 the FAC upon which to base their claims. (ECF No. 18 at 2-9.) The Court grants
14 Defendant's MTD as to Plaintiffs' second claim because NRS § 608.1555 is completely
15 preempted pursuant to ERISA's "deemer clause." However, because the Court declines
16 to exercise supplemental jurisdiction over the first claim, the MTD is denied as to Plaintiffs'
17 first claim.

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19 ¹⁶To the extent Plaintiffs contend that there is no ERISA plan at issue here (see ECF No. 17 at 3 as well as ECF No. 21 at 4), there is no basis to bring a claim for violation
20 of NRS § 608.1555 unless there is an "employee welfare benefit plan" within the meaning
21 of ERISA. If Defendant provides an employee health care plan that purchases policies
22 from commercial insurance companies (which is also considered an ERISA plan), then
23 those policies are directly regulated by NRS Chapters 689A and 689B, and NRS §
24 608.1555 would not be implicated. If Defendant does not provide an employee health
25 care plan whatsoever, then NRS § 608.1555 as well as NRS Chapters 689A and 689B
26 are not implicated at all either.

27 The Court notes that although it may consider facts outside the complaint when
28 determining whether remand is appropriate, see *Hamilton Materials, Inc. v. Dow Chem. Corp.*, 494 F.3d 1203, 1207 (9th Cir. 2007), the Court cannot rewrite the complaint to cure
legal deficiencies with a claim. Here, even though Plaintiffs appear to clarify the
allegations in the FAC to state that Defendant provides no employee health care plan
whatsoever, a violation of NRS § 608.1555 applies only where an employer chooses to
self-fund a plan and fails to ensure the plan provides the same benefits and coverage
required in NRS Chapters 689A and 689B. The Court need not give deference to how a
plaintiff labels its claim, rather the Court must look at the conduct on which the claim is
premised.

1 **A. Legal Standard**

2 Under Rule 12(b)(6), a complaint may be dismissed for “failure to state a claim
3 upon which relief can be granted.” Fed. R. Civ. P. 12(b)(6). A properly pleaded complaint
4 must provide “a short and plain statement of the claim showing that the pleader is entitled
5 to relief.” Fed. R. Civ. P. 8(a)(2); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007).
6 The Rule 8 notice pleading standard requires Plaintiff to “give the defendant fair notice of
7 what the . . . claim is and the grounds upon which it rests.” *Id.* (internal quotation marks
8 and citation omitted). While Rule 8 does not require detailed factual allegations, it
9 demands more than “labels and conclusions” or a “formulaic recitation of the elements of
10 a cause of action.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550
11 U.S. at 555). “Factual allegations must be enough to rise above the speculative level.”
12 *Twombly*, 550 U.S. at 555. Thus, to survive a motion to dismiss, a complaint must contain
13 sufficient factual matter to “state a claim to relief that is plausible on its face.” *Iqbal*, 556
14 U.S. at 678 (internal quotation marks omitted).

15 In *Iqbal*, the Supreme Court clarified the two-step approach district courts are to
16 apply when considering motions to dismiss. First, a district court must accept as true all
17 well-pleaded factual allegations in the complaint; however, legal conclusions are not
18 entitled to the assumption of truth. *Id.* at 678. Mere recitals of the elements of a cause of
19 action, supported only by conclusory statements, do not suffice. *Id.* Second, a district
20 court must consider whether the factual allegations in the complaint allege a plausible
21 claim for relief. *Id.* at 679. A claim is facially plausible when the plaintiff’s complaint alleges
22 facts that allow a court to draw a reasonable inference that the defendant is liable for the
23 alleged misconduct. *Id.* at 678. Where the complaint does not permit the court to infer
24 more than the mere possibility of misconduct, the complaint has “alleged — but it has not
25 show[n] — that the pleader is entitled to relief.” *Id.* at 679 (internal quotation marks
26 omitted). When the claims in a complaint have not crossed the line from conceivable to
27 plausible, the complaint must be dismissed. *Twombly*, 550 U.S. at 570. A complaint must
28 contain either direct or inferential allegations concerning “all the material elements

1 necessary to sustain recovery under *some* viable legal theory.” *Id.* at 562 (quoting *Car*
2 *Carriers, Inc. v. Ford Motor Co.*, 745 F.2d 1101, 1106 (7th Cir. 1989)).

3 **B. Discussion**

4 Plaintiffs argue that the second claim in the FAC is not preempted by ERISA in
5 part because NRS § 608.1555 does not refer to ERISA plans or apply solely to them and
6 also because “[t]here is no ERISA plan.” (See ECF No. 22 at 8-9.) As discussed at length
7 previously, see Discussion *supra* III.B, the Court disagrees with Plaintiffs’ reading of NRS
8 § 608.1555. The Court therefore rejects Plaintiffs’ argument and finds that NRS §
9 608.1555 is preempted pursuant to ERISA’s “deemer clause,” requiring dismissal of the
10 second claim.

11 Section 514(a) of ERISA states that ERISA “shall supersede any and all State laws
12 insofar as they . . . relate to any employee benefit plan” that is covered by the statute. 29
13 U.S.C. § 1144(a). While preemption does not apply to “any law of any State which
14 regulates insurance,” 29 U.S.C. § 1144(b)(2)(A), this exception to ERISA preemption is
15 limited by the statute’s “deemer clause,” which states that “an employee benefit plan . . .
16 shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged
17 in the business of insurance . . . for purposes of any law of any State purporting to regulate
18 insurance companies[] [or] insurance contracts.” 29 U.S.C. § 1144(b)(2)(B). Thus, state
19 laws that effectively “deem” an employee benefit plan to be an insurer or in the business
20 of insurance are preempted by ERISA. Moreover, the Supreme Court has held that self-
21 funded or uninsured plans are exempt from state laws that regulate insurance as well as
22 state laws that directly regulate those plans. See *FMC Corp.*, 498 U.S. at 61, 64.

23 While NRS Chapters 689A and 689B directly regulate insurance, see *supra* n. 15,
24 NRS § 608.1555 seeks to regulate self-funded or uninsured plans by “deeming”
25 employers who provide employee health care plans that self-insure to be in the business
26 of insurance and by treating these plans “as a policy of insurance” under NRS Chapters
27 689A and 689B. By doing so, NRS § 608.1555 falls squarely within the purview of
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1 ERISA's deemer clause and is preempted.¹⁷ Plaintiffs' second claim is therefore
2 dismissed with prejudice.

3 **V. REMAND**

4 Because of the dismissal of the claim that gives rise to federal question jurisdiction,
5 the Court declines to exercise supplemental jurisdiction over the remaining claim relating
6 to violation of the MWA. Therefore, the Court finds that remand is proper. See 28 U.S.C.
7 § 1447(c) ("If at any time before final judgment it appears that the district court lacks
8 subject matter jurisdiction, the case shall be remanded.").

9 **VI. CONCLUSION**

10 The Court notes that the parties made several arguments and cited to several
11 cases not discussed above. The Court has reviewed these arguments and cases and
12 determines that they do not warrant discussion as they do not affect the outcome of the
13 motions before the Court.

14 It is therefore ordered that Plaintiffs' Motion for Reconsideration of Order Denying
15 Remand (ECF No. 17) is denied.

16 It is further ordered that Defendant's Motion to Dismiss (ECF No. 18) is granted as
17 to Plaintiffs' second claim, which is dismissed with prejudice. The Court declines to
18 address the remaining state law claim.

19 It is further ordered that this action is remanded to state court.

20 DATED THIS 15th day of December 2017.

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MIRANDA M. DU
UNITED STATES DISTRICT JUDGE

17 In *Metropolitan Life Insurance Company v. Massachusetts*, the Supreme Court acknowledged that its interpretation "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not" and that "[b]y doing so [the Court] merely gives life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." 471 U.S. at 747.